Chapter 2: The Citizens We Support and Serve

Providing services to individuals with the most severe disabilities is the primary focus of the re-designed system. As legislatively directed, the Department established appropriate criteria to identify individuals with various disabilities. The criteria included not only diagnostic[3] and functional elements but also circumstances unique to each individual such as availability and access to appropriate services that meet the needs of each person. Criteria regarding the urgency and intensity of needs will be applied throughout the system to establish a structured process for prioritizing services and/or managing waiting lists.

The population described in this chapter-- the "target population"-- represents individuals with the most severe types of disabilities. The publicly sponsored mental health, developmental disabilities and substance abuse specialty system is the response arrangement for these individuals. However, there are several additional considerations to be made, as follows:

- Regardless if an individual is part of the target population, potentially, any citizen could seek services through the public system The system's response to such requests could include screening, triage and referral, as key examples. For individuals not in the target population who have the personal resources (insurance and ability to pay), the system's response could also include linking those persons to private non-publicly sponsored providers for longer term services-- post crisis individual therapy, as an example.

- Medicaid beneficiaries who have a condition that meets medical necessity for particular covered benefits are entitled to said benefits. These individuals are entitled to receive the supports, services, treatment and/or care regardless of whether they are identified as part of the state defined target populations. Medicaid beneficiaries who are not part of the state defined target populations, typically, require individual practitioner types of services that are less intensive and shorter term in duration. Medicaid beneficiaries who are included in the state defined target populations, generally, require supports, services, treatment and/or care that are more comprehensive, intensive and of longer duration. The best practices described in Chapter 3 are intended for these individuals and the system described in Chapter 4 are designed for these individuals.

- Individuals who are part of the state defined target populations who are not Medicaid beneficiaries are intended to be responded to by the publicly sponsored specialty system described in Chapter 4. However, the provision of services to these individuals is not an entitlement as in the case of Medicaid beneficiaries. Thus, the publicly sponsored specialty system is challenged with managing its available resources to meet the needs of these priority populations.

[3] Clinical diagnoses are made according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R). Classification for billing purposes is made according to the International Classification of Diseases (ICD-9).

Chapter 6 describes an extension of the transition period for the non-target populations. There are several factors that have led to this decision, as follows:

- **The need to better understand and establish the expectations regarding target population penetration rates.** This involves determining the number of people within the target populations that would be expected to be present in a community and the percentage of these people the system should be serving. Included among those would be individuals currently residing in state-operated institutions, out-of-state placements and out-of-county placements, virtually all of whom are part of the target populations. The process would also include identifying and ensuring access to individuals residing in the community who are part of the target population and who are not being served, are underserved or require different services.

- **The need to provide more time for the system itself to transition. There is variation around the state in terms of the numbers of target populations and non-target populations being served.** Community systems have been instructed to move to the target population while finding and/or sparking the development of other community resources to respond to the needs of the non-target populations (State Plan Communication Bulletin #003-- "Management of State Plan Target and Non-Target Populations"). This should continue, however we do not desire to simply extinguish needed services for these individuals. We are also continuing to learn of the need for some flexibility in the system for providing publicly sponsored services for these individuals – a "basic benefit" package. This "basic benefit" package will be less than the "enhanced benefit" available under the comprehensive specialty system but would be beyond the "core services" that are potentially available for all citizens.

- **The need throughout this continued process of transition of assuring the dedication of our limited resources to individuals in the target populations-- those with the most severe disabilities.** As reform public policy, this focus remains unchanged. The system can't opt to serve individuals with less severe needs while not sufficiently identifying and responding to the needs of the target population. Although there are limited alternatives for individuals who are not part of the target population, there are no other alternatives for individuals who are part of the target population.

Embracing Diversity

Across and within each of the disability groups – adult mental health, child mental health, developmental disabilities and substance abuse – particular attention is needed to embrace people who are at risk and/or have been traditionally underserved.

Nationally and in North Carolina, cultural and linguistic diversity is a growing challenge for health care delivery systems. During the last decade the number of people in need of health care services who have limited English proficiency has risen dramatically. For example, between 1990 and 2000, the Spanish speaking Latino population in North Carolina grew by almost 400%, giving North Carolina the fastest growing Latino population in the country. According to the 2000 United States

census, approximately half of North Carolina Latinos have limited English proficiency or are unable to speak English well. Such language barriers can impair a Latino's ability to access needed programs and services, and many are not knowledgeable about how the US health care system works.

Minority and ethnic groups are disproportionately represented within our present mh/dd/sa system. For example, according to the *Client Statistical Profile* for 2001-2002, African-Americans, who comprise 21.6 percent of North Carolina's population, made up 34 percent of persons served.[4] The Hispanic/Latino population represents approximately 5 percent of our state's population, yet are 1.74 percent of active service recipients.[5] There may be many reasons for variations in minority representation. These may include cultural and socioeconomic issues as well as concerns about stigma or negative attitudes toward people with disabilities.

Adults who are 65 or older have been shown to be at greater risk, are under identified and under served by the MH/DD/SA service delivery system, and they are an increasing component of North Carolina's population. The number of seniors in North Carolina has continued to grow rapidly in the last decade reflecting an increase in the general population and greater longevity. In North Carolina in 2000 there were 969,048 adults age 65 or older. This is 12 percent of the state's residents. These numbers are expected to rise rapidly as "baby boomers" approach retirement. By 2020, the population 65 and older will have grown 71 percent from the 2002 baseline compared to 36% for the general population. North Carolina's population over age 65 has a lower life expectancy, higher rates of poverty and lower average education and income than their national counterparts.

While many seniors are healthy, engaged and living in comfortable circumstances, others face declining health, poverty and social isolation. In 2000, 30.8 percent of people age 65 or older in the community reported some level of physical disability and 12.6 percent reported a mental disability. Forty seven percent of people age 85 or older have Alzheimer's disease. The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services, has noted that older adults often do not recognize the need for or availability of treatment. This results in a gross under utilization of mental health services.

Prevalence of mental health problems among adults 65 or older is as follows: 11.4 percent suffer with anxiety; 6.4 percent have cognitive impairments and 4.4 percent with depression and other mood disorders (SAMHSA 2002). Estimated prevalence for heavy alcohol use varies between 3 and 25 percent (SAMHSA 1998). Alcohol use can be a special problem for those over 65 who are often heavy users of prescription medicines and over-the-counter drugs. This use of prescription medications and over-the-counter drugs places these individuals at increased risk for misuse and adverse drug reactions. Older white men have a six times greater risk for suicide than the general population. It is also estimated that only half of older adults who acknowledge mental health

[4] African-Americans served represent 6 percent of the total African-American population in North Carolina.

[5] Hispanic/Latinos served represent 1.4 percent of the total Hispanic/Latino population in North Carolina.

problems receive treatment from any health care provider. The growth of the older population with developmental disabilities is also of major concern. These adults are increasingly outliving their parents and are at risk for losing their primary support. In North Carolina estimates for adults age 60 and over with developmental disabilities range from 5,400 to 13,000. Special attention will need to be given to securing the services and supports necessary to help these older adults remain in the community.

North Carolina's senior population is not a homogenous group but differs in race, ethnicity, gender, marital status and rurality, all of which are factors that affect their risk for mental health, developmental disabilities and substance abuse problems.

The prevalence rates for persons who are culturally deaf, that is, users of American Sign Language (ASL), are estimated at 0.49% of the general population (National Center for Health Statistics). Based on the 2000 Census, sign language users in North Carolina total approximately 37,500.

Culturally competent and language accessible systems demonstrate the capacity to communicate effectively with persons who are deaf or hard-of-hearing and persons with limited English ability and/or low literacy skills. Such organizations have policies, structures, practices, procedures and dedicated resources to support this capacity.

Significant barriers exist to the delivery of linguistically competent health care services. These include but are not limited to the following:

- Health care providers are not typically trained in cross-cultural approaches, which include working with interpreters as necessary to provide language accessible services.
- There are shortages in resources and qualified personnel to provide medical translation and interpretation services especially in rural areas.
- Segments of the immigrant and refugee population are unlikely to advocate for translation and interpretation services due to linguistic and cultural barriers, which include the perception of adverse political repercussions.

Accurate and honest communication between health care providers and consumers is essential to the effective delivery of quality health care services. Culturally competent and language accessible systems attempt to utilize bilingual professionals and paraprofessionals where available. Providing interpretation and translation services is another key strategy given the current population profiles and projected trends.

Strategies that local systems can use in addressing cultural and linguistic disparities include:

- Publishing written materials in languages reflective of the local population.
- Collaborating with the Minority Health Advisory Council on addressing barriers to services in local systems.
- Developing cultural competency.

- Using bi-lingual services as a paid skill.
- Making special efforts to recruit and hire qualified workers from different ethnic/racial groups.

While men and women with disabilities share many common experiences related to their conditions, systems need to recognize the fundamental differences as well. These differences are reflected in patterns of service utilization and in the life experiences of the individual. To meaningfully acknowledge these differences will require a shift away from gender-neutral service and system planning and a focus on unique needs. Systems better serve women when:

- Services are planned and evaluated with the involvement of women consumers and allied women's agencies.
- Services are provided with a holistic family-centered approach that includes services provided to children.
- Services and planning recognize consumer diversity in terms of ethno-cultural ancestry, heritage, age and sexual orientation.
- Impact of trauma/violence is acknowledged and addressed.
- Services sensitively and respectfully address issues related to sexuality, pregnancy and parenting.
- The benefits of woman-centered services are recognized, including housing and therapeutic settings in which a woman's privacy, security and social support needs are considered.
- The distinctive ways in which women experience dual conditions of mental illness, developmental disabilities and/or substance abuse are understood.
- Appropriate primary medical care is accessible for all aspects of physical health.

Part of the local planning process leading to local business plans was to include a thorough examination of the socioeconomic and ethnic/racial composition of each region and creation of strategies for meeting these special needs. Issues related to access to services and disparities in consumer outcomes by race/ethnicity, gender, sexual orientation, age, disability, geographical location, income and education level will be tracked as part of the outcomes system and will be included in report cards, published reports on outcomes.

Co-occurring Disorders

Individuals who meet the criteria for a target population often have more than one disability. People with severe and persistent mental illness (SPMI) or youth with severe emotional disturbance (SED) may also have a developmental disability, mental retardation and/or a substance abuse problem. Such a pattern can occur among all disabilities in any combination, although the co-occurring disorder(s), taken alone, may not reach the level of a target population in the second category(ies).

Generally, systems have done a poor job of recognizing and responding to these situations. Many organizations tend to focus their attention on specialized responses to a single disability – adult

mental health, child mental health, developmental disability or substance abuse – and fail to recognize and address accompanying problems. Sometimes public funding mechanisms and budgetary rules get in the way of appropriately addressing all of an individual's needs.

The State Plan for system reform adopts a cross-disability approach that requires response to all of the conditions that affect successful community living. Clinicians must be able to assess for co-occurring disorders, and treatment, and services and supports need to be integrated across all disabilities.

Adult Mental Health

According to estimates by the federal Center for Mental Health Services, during a 12-month period, approximately 5.4 percent of the adult population have a serious mental illness. This means that in North Carolina, during a 12-month period, approximately 322,000 adults have a diagnosable mental, emotional or behavioral disorder that has resulted in functional impairment that substantially interferes with or limits one or more major life activity. Within this population, approximately 99,000 have severe and persistent mental illnesses (SPMI) that interfere substantially with their ability to manage the demands of daily living.

Mental illnesses are disorders characterized by disturbances in a person's thoughts, emotions or behavior. The term "mental illness" can refer to a wide variety of disorders, ranging from those that cause mild distress to those that severely impair a person's ability to function.

The resources of the adult public mental health delivery system are targeted to adults with severe and serious mental illnesses. Within the resources available, the system will provide, at a minimum, a base level of service to all persons in the target population who seek services or who can be engaged through outreach activities. Additionally, as recommended in a study by the Public Consulting Group (PCG), priorities are established within target populations to guide the development and provision of specialty services and programs to people with the most significant disabilities. Recent advances in treatment for individuals with serious mental illness (SMI) and severe and persistent mental illness (SPMI) make it possible for individuals with these conditions to live far more satisfying lives than ever before. The system for adults with SPMI and SMI adopts a rehabilitation and recovery model focusing on providing or assisting individuals to obtain and maintain the skills they need to live as normally as possible in communities of their choice.

Adult Mental Health Target Populations for Community Services

Persons with severe and persistent mental illness (AMSPM)

People in this target population include adults, ages 18 and over, who meet diagnostic criteria and who as a result of a mental illness exhibit functioning that is so impaired as to interfere substantially with their capacity to remain in the community. The disability of these persons limits their functional capacities for activities of daily living such as interpersonal relations, homemaking, self-care, employment and recreation. The following diagnoses are included: schizophrenia, schizoaffective and schizophreniform disorders, bipolar disorder, major depressive disorder and psychotic disorder not otherwise specified. Functional status is assessed using the Global Assessment of Functioning (GAF).

Level of functioning criteria includes:

Any client who has or has ever had a GAF score of 40 or below.

OR

Current client who never had a GAF assessment when admitted

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

Current client who when admitted met level of functioning criteria but as a result of effective treatment does not currently meet level of functioning criteria

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 40 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available and who has a history of:

- Two or more psychiatric hospitalizations.

OR

- Two or more arrests.

OR

- Homelessness.

Must be reassessed annually or with significant change in functioning.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 40.

Persons with serious mental illness (AMSMI)

These are people 18 years or older who have a mental, behavioral, or emotional disorder that can be diagnosed and substantially interferes with one or more major life activities. These include delusional disorders, shared psychotic disorders, dissociative disorders, factitious disorders, obsessive-compulsive disorders, phobias, dysthymic disorder, borderline personality disorder, pedophilia, exhibitionism, anorexia, bulimia, post traumatic stress disorder, impulse control disorder and intermittent explosive disorder. Functional status is assessed using the GAF.

Adult, ages 18 and over, who meets diagnostic criteria and level of functioning criteria include:

Any client who has or has ever had a GAF score of 50 or below.

OR

Current client who never had a GAF assessment when admitted

AND

Who without ongoing treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

Current client who when admitted met level of functioning but as a result of effective treatment does not currently meet level of functioning criteria

AND

Who without continued treatment and supports would likely decompensate and again meet the level of functioning criteria (GAF score of 50 or below).

OR

New client who does not currently meet GAF criteria and no previous GAF score is available, and who has a history of:

- Two of more hospitalizations.

OR

- Two or more arrests.

OR

- Homelessness.

Must be reassessed annually or with significant change in functioning.

NOTE: An individual can remain in the target population even though his/her level of functioning might improve beyond the initial GAF score of 50.

Adult deaf or hard of hearing (AMDEF)

Adult, ages 18 or over, assessed as having special communication needs because of deafness or hearing loss and having a qualifying mental health diagnosis.

Adult homeless – PATH (AMPAT)

Adult, ages 18 and over, with a serious long-term mental illness or a serious long-term mental illness and substance abuse diagnosis, and is:

- Homeless, as defined by:

  (1) Lacks a fixed, regular and adequate nighttime residence.

  OR

  (2) Has a primary night-time residence that is:

    (a) Temporary shelter.

    or

    (b) Temporary residence for individuals who would otherwise be institutionalized.

    or

(c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

- At imminent risk of homelessness as defined by:

  (1) Due to be evicted or discharged from a stay of 30 days or less from a treatment facility.

  AND

  (2) Who lacks resources to obtain and/or maintain housing.

Must be reassessed annually.

Priority Populations within Target Populations (This is an all inclusive list.)

- **Persons with multiple diagnoses**: Persons 18 or older with a severe and persistent mental illness and a diagnosis of substance abuse and/or mental retardation or serious health problem including HIV disease.
- **Mentally ill adults in the criminal justice system**: Persons 18 or older with serious mental illness that are released from the Division of Prisons, or are in local jails or on probation.
- **Elderly persons**: Persons age 65 and over with a serious mental illness, including dementia.
- **Deaf mentally ill persons**: Persons 18 or older with a mental, behavioral or emotional disorder that can be diagnosed who need specialized services provided by staff who have American Sign Language skills and knowledge of deaf culture.
- **Minorities**: Adults with severe and persistent mental illness who are disproportionately represented in the system.

Adult Mental Health Target Populations for State Hospitals

In the next five years, state hospitals should revise their complement of beds and services to focus on their mission of providing psychiatric inpatient care to individuals with severe mental illness who cannot be appropriately treated in their local communities. Efforts already underway to prevent unnecessary institutionalization by directing people to local service providers whenever possible will continue.

Primary populations to be served among state hospitals

- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring brief acute inpatient treatment of a few days to stabilize and return to their communities.
- Adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders, requiring long-term inpatient rehabilitative

treatment of approximately three to six months, to prevent or correct a rapid relapse and readmission cycle, or who remain dangerous to self or others.

- Children with severe emotional disorders requiring acute inpatient treatment to stabilize and return to a less restrictive environment.
- Older adults with psychiatric illness including schizophrenia spectrum, bipolar disorder, major depression and some personality disorders requiring acute inpatient treatment to stabilize and return to their communities.
- Adults with psychiatric illness and substance abuse disorders, or serious illness such as HIV requiring acute and/or longer-term inpatient treatment to stabilize and prevent rapid relapse and readmission.

Specialty populations to be served

- Forensic patients, including those found incapable of proceeding with court trials (House Bill 95), not guilty by reason of insanity and other detainees.
- Patients taking part in a research protocol.
- Deaf consumers requiring acute or long-term inpatient psychiatric services.

Adult Mental Health Target Populations the NC Special Care Center

The mission of the NC Special Care Center is to provide intermediate and skilled nursing care for individuals referred from state hospitals and for people who can't be served in their communities because of insufficient bed-space and insufficient psychiatric services of the intensity needed.

Primary populations to be served

- Consumers with severe mental illness requiring ICF level of nursing care (intermediate care facility).
- Consumers with severe mental illness requiring SNF level of nursing level care (skilled nursing facility).

Specialty population to be served

Consumers with mid-stage Alzheimer's disease requiring nursing care.

Child Mental Health

North Carolina conservatively estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED). This is based on the prevalence rate cited in the Federal Register, June 1998. The NC Office of State Budget and Management estimates that there are 1,964,047 children in North Carolina under age 18 based on U.S. 2000 census data. The number of children in this age group with SED is between 196,404 and 235,686.

Seriously emotionally disturbed child with out-of-home placement (CMSED)

Child, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) as evidenced by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as indicated by one or more of the following:

- CAFAS score of at least 90; **OR**
- Total CAFAS score is greater than or equal to 70 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning; **OR**
- In need of specialized services from more than one child-serving agency (e.g. mental health provider(s) and DSS, DPI/schools, DJJDP, DPH, DCD or health care).

AND

Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:

- Utilizing or having utilized acute crisis intervention services or intensive wraparound services in order to maintain community placement within the past year.
- Having had three or more psychiatric hospitalizations or at least one hospitalization of 60 continuous days within the past year.
- Having had DSS substantiated abuse, neglect or dependency within the past year.
- Having been expelled from two or more daycare or pre-kindergarten situations within the past year.
- Having been adjudicated or convicted of a felony or two or more Class A1 misdemeanors in juvenile or adult court or placed in a youth development center, prison, juvenile detention center or jail within the past year.
- Situation exacerbated by special needs (e.g. physical disability that substantially interferes with functioning).

NOTES: This target population was designed to cross walk with Level D in the Child Levels of Care document (March 2002). For additional information please refer to this document.

Also for additional clarification regarding specific terminology used in eligibility determination, please refer to the Child Mental Health IPRS Eligibility Clarification document.

An individual determined eligible for this target population will have priority for funding if identified as:

- Sexually aggressive; and/or
- Deaf; and/or
- Having co-occurring disorders.

Seriously emotionally disturbed child (CMMED)

Child, under the age of 18, with atypical development (up to age five) or serious emotional disturbance (SED) by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as evidenced by one or more of the following:

- CAFAS score of at least 60; **OR**
- Total CAFAS score greater than or equal to 40 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

NOTES: This target population was designed to cross walk with Level C in the Child Levels of Care document (March 2002). For additional information, please refer to this document.

Deaf or hard of hearing child (CMDEF)

Child, under the age of 18, who is assessed as deaf or as needing specialized mental health services due to social, linguistic or cultural needs associated with individual or familial deafness or hearing loss;

AND

The presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.

NOTES: Deaf children will be dually enrolled as both Deaf/HH and in their appropriate population category, or order to receive a full array of services. Where this funding is available, it will be depleted before other funding sources pay for the eligible service.

Homeless child – PATH (CMPAT)

Child, under the age of 18, who has serious emotional disturbance (SED) and has an ICD-9 diagnosis(es) and is;

Homeless, as defined by:

- Lacks a fixed, regular, adequate night-time residence; **OR**
- Has a primary night-time residence that is:

  (a) Temporary shelter; **or**

  (b) Temporary residence for individuals who would otherwise be institutionalized; **or**

  (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

- Due to be evicted or discharged from a stay of 30 days or less from a treatment facility

AND

- Who lacks resources to obtain and/or maintain housing.

NOTES: There is no specific requirement regarding functioning as measured by a CAFAS score. Assertive outreach can be provided to homeless persons who have a deferred diagnosis.

Developmental Disabilities

The Division's developmental disabilities services follow recommendations of the National Association of State Directors of Developmental Disabilities Services and use the University of Minnesota's figure of 1.58 percent as a broad estimate of people in the total population with developmental disabilities. This means that there are approximately 130,810 people in NC with developmental disabilities.

Adult with developmental disability (ADSN)

Adult, ages 18 and over, screened eligible as developmentally disabled in accordance with the current functional definition in G.S. 122C-3(12a).

Developmental disability assessment based on NC SNAP 1 through 5.

NOTES:

Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and,
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.

Child with developmental disability (CDSN)

Child, under the age of 18, screened eligible as developmentally disabled in accordance with the current functional definition in G.S. 122C-3(12a).

Developmental disability assessment based on NC SNAP 1 through 5.

NOTES: Developmental disability means a severe, chronic disability of a person that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;

- Is manifested before the person attains age 22, unless the disability is caused by a traumatic head injury and is manifested after age 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, capacity for independent living, learning, mobility, self-direction and economic self-sufficiency; and,
- Reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated.

Developmental Disabilities Target Population for Community Services

In the late 1980's, North Carolina adopted the federal functional definition of developmental disability, which in essence targeted the population to those most impacted by disability. While this definition presumes that mental illness is not the cause or origin of the primary disability, it is acknowledged that those individuals who meet this functional definition may experience a co-occurring mental illness.

Developmental disability services are provided throughout a broad and diverse population. The target population is created by the application of a functional rather than diagnostic definition and is applicable throughout the lifetime of most individuals who are eligible for services. Since people with developmental disabilities, uncomplicated by secondary conditions, do not have an illness that is amenable to medical treatment, services and supports for these individuals focus almost entirely on interventions that strengthen the individual's ability to manage community living conditions and maintain or build a reliable personal support system.

All people currently in services meet the target population criteria, but they may be receiving services/supports in excess of or inappropriate to their level of need. The requirement in the new system for re-assessment of individuals already receiving services is to correct any inappropriate or excessive services that currently exist.

Substance Abuse

Data used in making projections of treatment needs are taken from North Carolina's first Center for Substance Abuse Treatment (CSAT) needs assessment studies conducted by the Research Triangle Institute. Estimates of people needing substance abuse services include:

- 784,000 people age 18 and above who needed substance abuse services.
- 2,600 homeless.
- 2,700 psychiatric patients.
- 9,700 imprisoned believed to be in need of substance abuse services.
- 47,555 public high school students.
- 4,917 school dropouts.
- 666 private school students.

Substance Abuse Target Population

The most significant opportunity to reduce the burden of substance abuse on public programs is through targeted and effective prevention programs. If children and youth under age 21 can be kept from smoking cigarettes, using illicit drugs and abusing alcohol, the risk for future addiction is substantially reduced. Treatment is also a cost-effective intervention, as it reduces the costs to state programs in the short term and avoids future costs. North Carolina will make targeted interventions for selected populations that hold promise for high return. As savings and new resources become available to expand service system capacity, additional populations will be added to the list of those targeted for services.

Target populations for substance abuse services (eligibility criteria)

All individuals will be assessed for service eligibility on the basis of the American Society of Addiction Medicine (ASAM) patient placement criteria for the treatment of substance-related disorders (PPC).

Adult Substance Abuse

Adult injecting drug user/communicable disease (ASCDR)

Injecting drug users, those with communicable disease and/or those enrolled in opioid treatment programs, are those adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and:

- Who are currently (or within the past 30 days) injecting a drug under the skin, into a muscle or into a vein for non-medically sanctioned reasons and who meet ICD-9 criteria for a substance-related disorder.

OR

- Who are infected with HIV, tuberculosis or hepatitis B, C or D and who meet ICD-9 criteria for a substance-related disorder.

OR

- Who meet ICD-9 criteria for dependence to a opioid drug, are addicted at least one year before admission, are 18 years of age or older, and who are enrolled in an opioid treatment program.

Adult substance abuse women (ASWOM)

Adult women who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance-related disorder who are:

- Currently pregnant.

OR

- Have dependent children under 18 years of age.

OR

- Who are seeking custody of a child under 18 years of age.

Adult substance abuse DSS-involved parents (ASDSS)

DSS involved adults who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, and are substance abusers who meet ICD-9 criteria for substance-related disorder include those who:

(1) Are parents who have legal custody of a child or children under 18 years of age.

AND

(2) Where there is a Child Protective Services report for child abuse, neglect or dependence that is being assessed, or where there is a finding of a need for Child Protective Services or a case decision of substantiation by Child Protective Services, OR who are authorized by DSS to receive Work First Assistance and/or services.

OR

(1) Are DSS involved individuals who have been convicted of a Class H or I Controlled Substance Felony in North Carolina, and who are applicants for or a recipient of food stamps.

Adult substance abuse high management (ASHMT)

High management adult substance abusers, who are in need of treatment for a primary alcohol or drug abuse disorder, with an ICD-9 substance dependence disorder, are those individuals who are ages 18 and over, and who:

1. Are currently involuntarily committee to substance abuse treatment (legally determined to be dangerous to self or others and may have co-occurring mental illness).

OR

2. Have a substance use pattern of recurring episodes of chronic use with unsuccessful attempts at recovery (or unsuccessful attempts by the provider to engage the chronically ill individual in treatment).

   AND

   Have a history of one or more unsuccessful treatment episodes, which may include assisted detoxification. The individual is advanced in their disease, has limited social or environmental supports, and has few coping skills. The individual may also be resistive to treatment, or have co-occurring disorders, or have moderate biomedical conditions.

Adult substance abuse criminal justice offender (ASCJO)

Substance abusing adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who are involved in the criminal justice system, and:

1. Who meet ICD-9 criteria for a substance-related disorder;

   AND

2. Whose services are approved by a TASC program care manager;

AND

3. Who voluntarily consent to participate in substance abuse treatment services;

   AND

4. Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Adult substance abuse driving while impaired treatment (ASDWI)

Adults, ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder, who have an ICD-9 substance-related disorder and:

1. Have been arrested for:
   - Driving while impaired (DWI), **OR**
   - Commercial DWI, **OR**
   - Driving while less than 21 years old after consuming alcohol or drugs.

   AND

2. Must have completed a DWI assessment and been identified with a substance abuse handicap.

   AND

3. Client must pay for initial $125 in fees for assessment and treatment.

   AND

4. Have an income level of 200% or less of the federal poverty level.

Note: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Adult substance abuse deaf and hard of hearing (ASDHH)

Adult clients who are ages 18 or over, who are in need of treatment for a primary alcohol or drug abuse disorder, and who have an ICD-9 substance-related disorder and who have been assessed as having special communication needs because of deafness or hearing loss.

Adult substance abuse homeless (ASHOM)

Adult clients who are ages 18 and over, who are in need of treatment for a primary alcohol or drug abuse disorder and who meet the criteria for any of the following IPRS target population categories:

- Injecting drug user/communicable disease risk (ASCDR)
- Criminal justice offender (ASCJO)
- DSS-involved (ASDSS)

- DWI treatment (ASDWI)
- High management (ASHMT)
- Women (ASWOM)
- Deaf and hard of hearing (ASDHH)

AND IS

Homeless, as defined by:

1. Lacks a fixed, regular and adequate nighttime residence.

   OR

2. Has a primary night-time residence that is:
   - Temporary shelter, **or**
   - Temporary residence for individuals who would otherwise be institutionalized, **or**
   - Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

1. Due to be evicted or discharged from a stay of 30 days or less from a treatment facility.

AND

2. Who lacks resources to obtain and/or maintain housing.

Child and Adolescent Substance Abuse

Child with substance abuse disorder (CSSAD)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder.

Child Substance Abuse Women (CSWOM)

Adolescent women who are under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder, and who are:

- Currently pregnant.

OR

- Have dependent children under 18 years of age in her custody or for whom she is seeking such custody.

Child substance abuse selective prevention (CSSP)

A child or adolescent under 18 years of age determined to be at elevated risk for substance abuse and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school

OR

- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning, or escort.

OR

- Has one or both parents, legal guardians, or caregivers that have one or more documented child abuse or neglect reports, investigations or substantiated incidents involving DSS.

OR

- Has one or both parents, legal guardians, or caregivers that have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet the criteria for other conditions that may be a focus of clinical attention. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse indicated prevention (CSIP)

Child or adolescent under 18 years of age who is using alcohol or other drugs at a pre-clinical level (child or adolescent does not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria) and who:

- Is currently experiencing, or in the previous six months has experienced, documented school related problems or educational attainment difficulties including school failure, truancy, suspension or expulsion or dropping out of school.

OR

- Has documented negative involvement within the previous six months with law enforcement or the courts including formal and informal contacts such as arrest, detention, adjudication, warning or escort.

OR

- Has one or both parents, legal guardians or caregivers that have one or more documented child abuse or neglect reports, investigations or substantiated investigations involving DSS.

OR

- Has one or both parents, legal guardians or caregivers that have a documented substance-related disorder.

NOTE: Individuals do not meet criteria for a substance-related disorder or a mental health disorder, but may meet other criteria. Recipients will be individually identified, client records will be maintained, and designated consumer prevention outcomes will be tracked.

Child substance abuse criminal justice offender (CSCJO)

Substance abusing adolescent clients who are under the age of 18, who are in need of treatment for a primary alcohol or rug abuse disorder, and who are involved in the criminal justice system and:

- Who have a primary ICD-9 substance-related disorder.

AND

- Whose services are authorized by a TASC program care manager.

AND

- Who voluntarily consent to participate in substance abuse treatment services.

AND

- Who are Intermediate Punishment offenders OR who are Department of Correction releasees (parole or post-release) who have completed a treatment program while in custody OR who are Community Punishment Violators at-risk for revocation.

Child substance abuse DWI Treatment (CSDWI)

Adolescents under the age of 18, who are in need of treatment for a primary alcohol or drug abuse disorder, who have a primary ICD-9 substance-related disorder and:

- Have been arrested for:
  - Driving wile impaired (DWI), **or**
  - Commercial DWI, **or**
  - Driving while less than 21 years old after consuming alcohol or drugs.

AND

- Must have completed a DWI Assessment and been identified with a substance abuse handicap.

AND

- Client must pay for initial $125 in fees for assessment and treatment.

AND

- Have an income level of 200% or less of the federal poverty level.

NOTE: The intent of this eligibility category is to provide necessary access to treatment for eligible individuals who cannot pay for services through first or third party payment and who are seeking substance abuse treatment that is required in order for the individual to obtain a Certificate of Completion required under General Statute as a condition for the restoration of a driver's license.

Child in the MAJORS substance abuse/juvenile justice program (CSMAJ)

Child or adolescent, under the age of 18, who is in need of treatment for a primary alcohol or drug abuse disorder, with a primary ICD-9 substance-related disorder.

AND

Is enrolled in the MAJORS substance abuse/juvenile justice program.

Priorities within Target Populations

- Adult and child pregnant injecting drug users.
- Adult and child pregnant substance abusers.
- Adult and child injecting drug users.
- Children and adolescents who are involved in the juvenile justice or the social services system, who are having problems in school or whose parent(s) are receiving substance abuse treatment services.
- Adult and child deaf persons who need special services provided by staff who have American Sign Language skills and knowledge of the deaf culture.
- Adult and child clients who have co-occurring physical disabilities.
- Adult and child homeless clients
- All others.

Persons with Substance Abuse and Mental Illness

LMEs will be required to ensure that services are provided to individuals who experience substance abuse problems along with co-existing physical or cognitive disability. All services to adults with multiple disorders should address both the mental health and substance abuse needs in a coordinated, integrated manner. The primary responsibility shall be assigned as described here:

- Adult mental health services shall have primary responsibility for mentally ill individuals who also abuse substances. This includes adults who have a diagnosis of severe and persistent mental illness, including schizophrenia, bipolar disorder, schizoaffective disorder, recurrent major depression or borderline personality disorder, and in addition have a substance abuse problem.
- Substance abuse services shall have primary responsibility for consumers with substance abuse/dependence disorders who also have a mental illness. This includes adults who carry a diagnosis of substance abuse/dependence and, in addition, have a mental health diagnosis other than those listed above, which could include other Axis II disorders.